HOSPICE SERVICES PAYMENT SYSTEM

*payment***basics**

The Medicare hospice benefit covers a broad set of palliative services for beneficiaries who have a life expectancy of six months or less, as determined by their physician. Beneficiaries who elect the Medicare hospice benefit agree to forgo curative treatment for their terminal condition. For conditions unrelated to their terminal illness, Medicare continues to cover items and services outside of hospice. Typically, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities and other inpatient settings. Hospice providers can be freestanding entities or based in hospitals, skilled nursing facilities, or home health agencies.

CMS data show continued acceleration in use of the hospice benefit and associated spending. From 1998 to 2002, the percentage of beneficiaries using hospice before they died grew from 20 percent to 26 percent. The total number of providers has also increased. In 2003, there were 2,454 hospices, an 8 percent increase in the number of hospice providers since 2001. During this same time period the number of for-profit hospices grew 25 percent. Medicare spending on hospice has grown considerably in the past ten years—from $1.9 billion in 1995 to an estimated $7 billion in 2004. Spending on hospice makes up 2 percent of total Medicare spending.

The hospice product and Medicare payment

The hospice benefit is designed to provide pain relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis. To provide this type of care, the benefit covers an array of services, such as:

- skilled nursing services,
- drugs and biologicals for pain control and symptom management,
- physical, occupational, and speech therapy,
- counseling (dietary, spiritual, family bereavement, and other counseling services),
- home health aide and homemaker services,
- short-term inpatient care,
- inpatient respite care, and
- other services necessary for the palliation and management of the terminal illness.

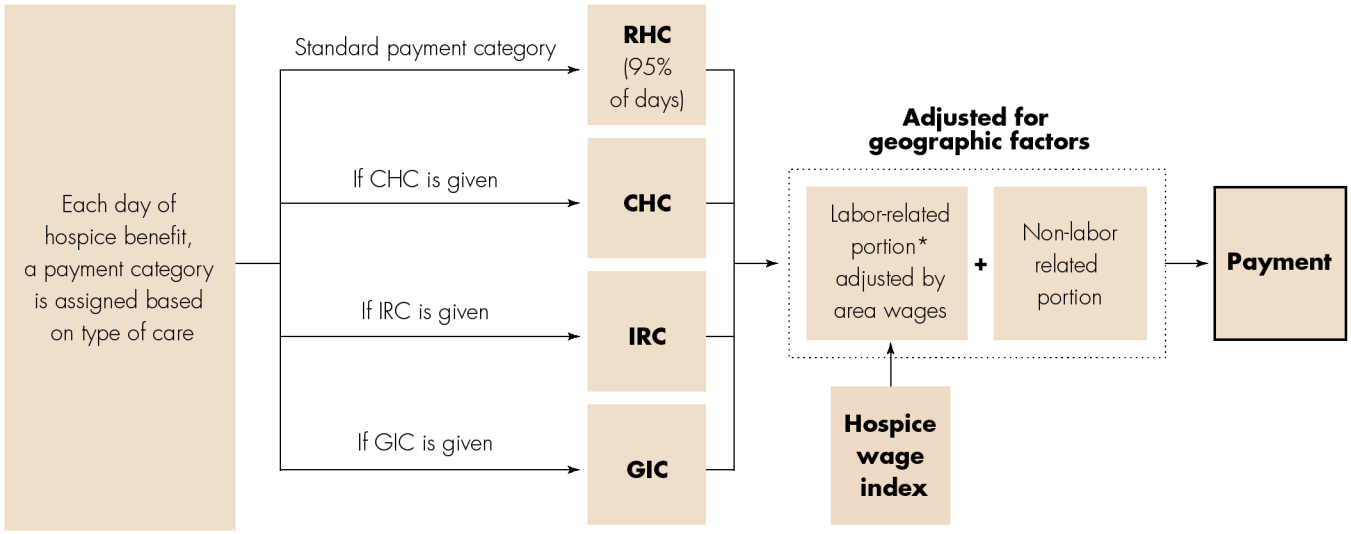
Setting the payment rates

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit (Figure 1). Medicare makes a daily payment, regardless of the amount of services provided on a given day and even on days when no services are provided. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans. Payments are made according to a fee schedule that has four base payment amounts for the four different categories of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC) (Table 1). The four categories are distinguished by the location and intensity of the services provided and the base payments for each category reflect variation in expected input cost differences. Unless a hospice provides CHC, IRC, or GIC on any given day it is paid at the RHC rate. For any given patient, the type of care can vary throughout the hospice stay as the patient's needs change. Ninety-five percent of days of hospice care provided are at the routine home care level.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each category

MEDPAC
601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Hospice prospective payment system



Note: RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care).
*The labor-related portion adjusted by the wage index varies, depending on payment category (see Table 1). Wage index adjustment is based on the location of the patient, not the hospice agency.

of care's base rate has a labor share and a nonlabor share; those amounts differ across each category. The labor share of the base payment amount is adjusted by the hospice wage index for the location in which care is furnished and the result is added to the nonlabor portion. The base rates are updated annually based on the hospital market basket index.

Two caps limit the amount and cost of care that any individual hospice agency provides in a single year. One cap limits the number of days of inpatient care an agency may provide to not more than 20 percent of its total patient care days. The other cap is an absolute dollar amount, based on the number of Medicare patients

Table 1 Hospice payment categories and rates

Category of care	Description	Base payment rate, FY 2006	Labor-related portion of payment adjusted by the wage index, FY 2006
RHC	Home care provided on a typical day	$126	69%
CHC	Home care provided during periods of patient crisis	738	69
IRC	Inpatient care for a short period to provide respite for primary caregiver	131	54
GIC	Inpatient care to treat symptoms that cannot be managed in another setting	563	64

Note: FY (fiscal year), RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care). Payment for CHC is an hourly rate ($738.26=24 hours of care at $30.76 per hour) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. In addition, a nurse must deliver half of the hours of this care to qualify for CHC-level payment.

Source: CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 655, "Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2006."

the agency serves. Total payments over total number of beneficiaries may not exceed $19,776 in the year ending October 31, 2005. Unlike the daily rates, the caps are not adjusted for geographic differences in costs. The hospice caps are adjusted annually by the medical expenditure category of the consumer price index for all urban consumers.

Hospice payments were calculated based on information from a Medicare demonstration project completed in the early 1980s. The set of services included in the payment has not been examined or recalibrated since then to reflect possible changes in patterns of hospice care and associated costs.

Beneficiary liability for hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside of the inpatient setting, but the coinsurance may not exceed $5 per drug. For inpatient respite care, beneficiaries are liable for 5 percent of Medicare's respite care payment per day. Beneficiary coinsurance for respite care may not exceed the Part A inpatient hospital deductible, which was $952 in 2006. ■